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What Is Long-Term Care?

Long-term care is the assistance or supervision you may need when you are not able to do some of the basic “activities of daily living” (ADLs) like bathing, dressing or moving from a bed to a chair. You might need assistance with ADLs if you suffer from an injury like a broken hip, an illness, a stroke or from advanced age and frailty. Other people may need long-term care because of mental deterioration, called “cognitive impairment” that can be caused by Alzheimer’s Disease, other mental illness or brain disorders.

Long-term care is sometimes called “custodial care” or “personal care”. *Formal long-term care* (the kind of care you must pay for) is most often provided by professional skilled and unskilled workers. Unskilled workers are often supervised by skilled medical personnel such as registered nurses. *Informal long-term care* is frequently provided by unpaid family members and friends.

Long-term care services can be provided in your own home or in a community program like an Adult Day Care Center, in an assisted living facility licensed as a Residential Care Facility for the Elderly (RCFE), or in a nursing home.

Long-term care is not necessarily “long term.” For instance, about half of all nursing home stays last 6 months or less. Some people only need long-term care for a few months, for example, while recovering at home from a broken hip, while others may need care for the rest of their life.

Will I Need Long-Term Care?

Your personal risk of needing long-term care depends on many factors. Some of those are whether you are male or female, how long you live, your health history and whether you have a spouse or family member who can provide some of the care you may need.

Longevity: The longer you live, the more likely it is that you will need long-term care. Those who live to be 95 years old or older are much more likely to have spent five or more years in a nursing home than those who die in their mid-70’s. Much less is known about the use of home care services.

Your Gender: Women are at a much higher risk of needing to pay for formal long-term care for several reasons. Women not only have longer life spans, they often out-live their spouses. When they need long-term care in their older years, there is often no one to care for them at home and they are more likely to need institutional care as a result of all these factors.

Married or Single: If you have a spouse or other family members who can provide care you are more likely to be able to remain in your own home when you need care. If family members are unable to provide care, and you cannot pay someone to take care of you, then a nursing home may be the only available option. The condition that causes you to need care, and the severity of that condition, may determine whether you can be cared for at home or whether institutional care is the only option. For instance, a severe stroke could be so disabling that care at home is impossible, or an Alzheimer’s patient may need constant supervision.

Health factors: Certain health conditions, like Alzheimer's or a stroke, can cause a need for long-term care. If you know that certain health conditions run in your family, you may have a greater risk of needing long-term care than another person of the same age and gender. Unfortunately, it may be that this known health condition could also make you ineligible to buy this type of insurance.

How Much Does Long-Term Care Cost?

In 2002, the cost of nursing home care in California averages \$141 a day. Costs may be lower in rural areas and higher in suburban and urban areas. A short 30-day stay could cost \$4,230 or more; a 3 month stay, \$12,690 or more; and, a year stay, \$50,000 or more. The cost of care in the future will be much higher than it is today. California nursing home rates increased at an average rate of over 5% per year during the past twenty years¹ and are likely in the future to continue to increase by at least 5% per year. A 5% annual increase means a year of care that costs \$50,000 today will cost twice that amount in 14 years, or \$100,000 a year!

¹ Issuers Bulletin for 2002, California Partnership for Long-Term Care, based on data from the California Office of Statewide Health Planning and Development.

Who Usually Pays for Long-Term Care?

- **Medicare** may pay for skilled care in a nursing home for a very short period of time – but no longer than 100 days – and only when the patient meets all the Medicare requirements for daily skilled care. While people do get personal care services at the same time, Medicare will not pay unless there is also a need for daily skilled services that only a nurse or therapist can provide. Medicare may pay for some personal care services at home but again, only if you also need skilled care on a daily basis that only a licensed person can provide. For more details, see the Medicare benefits book available from your Social Security office or by calling the Social Security Administration, toll-free at 800-772-1213.
- **Medi-Cal** (called Medicaid outside California) pays for necessary health care that is not covered by Medicare, but only if you meet federal and state poverty guidelines. In 2002, a single person over 65 would qualify for Medi-Cal if he/she had \$2,000 or less in non-housing assets. A married spouse, living in the community, however, can keep up to \$89,280 in non-housing assets and \$2,232 in joint monthly income, when his or her spouse is in a nursing home and applies for Medi-Cal. These guidelines and the amount of assets and income a person may keep can change annually.

Note: Non-housing assets are mentioned several times in this guide. In general, the value of a person's house is not counted when applying for Medi-Cal. While the state does have estate recovery rights after the death of a Medi-Cal beneficiary, there are certain exemptions that apply, particularly for surviving spouses. There are certain rules that the state must follow if it is to be successful in recovering any amounts the program paid. You can get the most current information about Medi-Cal from your local county Department of Social Services, Legal Services Program, or an elder law attorney.

- **Personal Resources:** Most people pay long-term care expenses from their own income and resources. When care is provided by family members and friends at home, necessary skilled care such as equipment, transportation and other costs not paid by Medicare are also paid from the patient's personal income or savings. People who use up their assets paying for long-term care are "spending down" and may become eligible for Medi-Cal as a result.
- **Long-Term Care Insurance** is designed to pay a portion of long-term care costs. It is available from private insurance companies selling in California. This type of insurance may be cost-effective for you if you have sufficient available income to pay the premiums for the rest of your life.

What Is Long-Term Care Insurance?

Long-Term care insurance covers any of the following:

1. **Care in a Facility** that is not an acute-care hospital. Some of the terms used to describe these "facilities" that can provide long-term care services include nursing homes, Residential Care Facilities for the Elderly (RCFE) often called Assisted Living Facilities, convalescent facilities, extended care facilities, custodial care facilities, skilled nursing facilities or personal care homes.
2. **Home Care** including Home Health Care, Personal Care, Homemaker Services, Hospice Services or Respite Care. (Some Hospice and Respite care can also be received in a facility like a nursing home.)
3. **Community-Based Care** such as Adult Day Care or Hospice Facility Care.

In California, only 3 categories of long-term care insurance policies can be sold. Each policy is labeled as:

- a. **Nursing Facility and Residential Care Facility Only.** These policies cover skilled, intermediate, or custodial care in a nursing home or similar facility. These policies also pay for assisted living care in a Residential Care Facility for the Elderly (RCFE) but Home Care is not covered.
- b. **Home Care Only.** These policies are required to pay for: Home Health Care, Adult Day Care, Personal Care, Homemaker Services, Hospice Services and Respite Care but care in a facility is not covered.
- c. **Comprehensive Long-Term Care.** These policies pay for nursing facility care, assisted living care in an RCFE, and home and community care. These policies must include at least 8 benefits: a nursing home benefit, an RCFE benefit for assisted living, and the 6 home care benefits: Home Health Care, Adult Day Care, Personal Care, Homemaker Services, Hospice Service and Respite Care.

The California Partnership for Long-Term Care (the Partnership), a program of the California Department of Health Services (DHS), is an innovative partnership between consumers, the State of California and six private insurance companies, plus the California Public Employees Retirement System (CALPERS). These insurers offer a special type of long-term care insurance policy, commonly called "Partnership" policies, that must meet certain requirements set by the DHS. Insurance companies participating in the Partnership program must have their Partnership policies approved by both the Department of Insurance and the DHS. Additionally, only agents who have received special training are

able to sell you a Partnership policy and to advise you as to whether the Partnership program works for you. Be sure to confirm that your agent has this special certification to sell Partnership policies.

Each Partnership-approved policy includes high quality insurance benefits to cover the care you may need and automatic inflation protection to ensure that the benefits keep pace with the rising cost of care. Partnership policies also include a unique state guaranteed asset protection feature that protects you against impoverishment due to the costs of long-term care, even if you use up all the benefits of your policy.

The unique Medi-Cal asset protection feature of a Partnership-approved insurance policy allows you to keep a dollar of assets for every dollar your policy pays out in benefits. If you still need long-term care after you use up your policy benefits, you can apply to Medi-Cal and Medi-Cal will allow you to keep assets, above what Medi-Cal normally allows, equal to the amount of benefits the Partnership policy paid out for your care. This protected amount of assets will not be counted in your application for Medi-Cal benefits. These assets are also protected as part of your estate so your loved ones will receive them. Only a Partnership-approved insurance policy can provide you with both the benefits you may need and guaranteed lifetime asset protection so you will not be forced to spend everything you have worked for on long-term care.

Partnership policies also have other important features that are not required in other long-term care insurance policies. To learn more about these policies and the companies that are approved to sell them, call the Partnership for free brochures at 800-CARE445 (800-227-3445).

What Is a Tax Qualified Long-Term Care Policy?

Congress passed legislation effective in 1997 that established the tax treatment of premiums paid for and the benefits paid by long-term care insurance policies that met certain federal standards. This legislation is called the Health Insurance Portability and Accountability Act or HIPAA.

Long-term care policies that use the federal standards to pay benefits are labeled as “Federally Tax Qualified”. Some or all of the premiums for these federally tax qualified policies may be deductible as a medical expense on your federal and California income tax returns (depending on your age and the amount of annual premium). In addition, the benefit payments are excluded from income.

Note: Premiums paid for a tax-qualified policy, qualify as a medical expense. People who itemize medical expenses on their federal tax return and have total medical expenses greater than 7.5 percent of their adjusted gross income may be able to deduct all or some portion of the premiums paid for one of these policies. **The benefits received from a tax-qualified long-term care policy are not taxable income on both Federal and California tax returns.**

Employers who provide tax-qualified long-term care insurance for their employees may deduct the premiums they pay as they do for other accident and health insurance policies. This employer contribution would not be considered income to the employees.

Policies sold as federally tax qualified long-term care insurance use a standard of eligibility for benefits that may be stricter than the standards established in California for non-qualified policies. It may be easier to qualify for benefits from non-tax qualified policies that use the standards established by California. However, the premiums for these non-tax qualified policies cannot be deducted and federal law is unclear on the tax treatment of the benefits paid.

If you have questions about the tax status of a policy you own or one you are considering buying, your qualified long-term care insurance agent can advise you. If you have specific questions pertaining to how the purchase of tax qualified long-term care insurance will impact the deductions you take or the taxes you pay, you should talk to your tax advisor to see how it will affect your individual taxes.

Note: All long-term care policies that were issued prior to January 1, 1997 automatically qualify as federally tax qualified policies. These pre-1997 issued policies are "grandfathered" - i.e. they qualify for the same tax treatment of premiums and benefits paid as new policies issued after 1997 that are federally tax qualified. These policies do not have to be replaced with a new tax qualified policy in order for the premiums to be tax deductible. In fact, you should be quite careful when considering changing or replacing any long-term care insurance policy issued prior to January 1, 1997 because you may lose the policy's grandfathered status and you will have to meet a stricter standard to qualify for benefits. Consult your agent, insurance company or tax advisor for more information.

Individual vs. Group Insurance

An individual long-term care insurance policy is a contract between you and the insurer. These policies must be approved by the California Department of Insurance (CDI) and have all of the consumer protections required under California law. Individual policies are "guaranteed renewable" and cannot be canceled by the insurance company unless the premium is not paid on time. However, every company has the right to increase the premiums it charges with proper notification and approval from the Department of Insurance.

Group long-term care insurance is a contract between an insurer and a group, such as an employer on behalf of its employees, or a trade or professional association on behalf of its members. If you are covered under a group plan, you receive a "certificate" rather than a "policy" of insurance. Also, many of the policy terms have already been negotiated by the group, and the group (called the "master policyholder") has the option to terminate the policy at any time. Often, but not always, group insurance is less expensive than individual insurance. If group coverage is terminated, you have the right to continue the coverage or buy a conversion policy, depending on the provisions of the policy and other factors. If you purchase group coverage, ask about what options will be available to you if the group cancels the policy or if you lose your membership or eligibility. Be sure to ask if the premiums will change, and ask how you will be notified.

Note: If you are considering buying group insurance, investigate the sponsoring group. Be sure the group is negotiating in your interest. Some group policies do not have to be approved by the California Department of Insurance, although the company is required to send information about the policy to the Department for its records. The master policy can be cancelled by the carrier or the sponsoring group, at its option.

What Services Do Insurance Policies Cover?

Insurance policies describe where they will pay for care, what kind of care they will pay for, who can provide the care, and conditions that have to be met before a company will pay benefits. Described below are the services required in a long-term care insurance policy approved under current state law. You should be aware however, that California law has changed many times over the years, and that insurance policies sold in previous years may have different requirements than are shown here.

Facility Coverage: In California, most skilled, intermediate and custodial care is received in nursing homes that are licensed as “skilled nursing facilities”. All long-term care policies except Home Care Only cover this kind of care.

Policies sold after October, 2001 (except Home Care Only policies) are required to include a benefit to cover care in an assisted living facility licensed as a Residential Care Facility for the Elderly (RCFE). Some insurance policies sold before October, 2001 also include this benefit. RCFE’s are not nursing homes, but living arrangements where a person can also receive personal care or supervision. Some RCFEs are large retirement homes, while others are small group homes.

Home Care Coverage: Every long-term care insurance policy called “Home Care Only” or “Comprehensive Long-Term Care” issued after January 1, 1993 must include at least the following 6 Home Care benefits and other consumer protections which should make it easier to receive care at home.

1. **Home Health Care** is skilled nursing care or other professional services in your residence.
2. **Adult Day Care** is medical or social care in a daytime program in a licensed facility which provides personal care, supervision, protection, or assistance in the following: eating, bathing, dressing, moving about and taking medications.
3. **Personal Care** is assistance with any of the Activities of Daily Living or ADLs including Instrumental Activities of Daily Living (IADLs) such as using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, doing laundry and light housekeeping.

Under California law, these services may be provided by a skilled or unskilled person as long as they are required in a Plan of Care developed by your doctor or a team of health care workers under medical direction.

4. **Homemaker Services** assist you with tasks or activities such as cooking, cleaning and other activities to help you remain in your home.
5. **Hospice Services** are services in your residence designed to provide physical, emotional, social and spiritual support for you, your caregiver and your family when a terminal illness has been diagnosed. Some policies will pay for these services in an institutional setting as well.

Under California law, these services (like Personal Care) may be provided by a skilled or unskilled person so long as they are required in a Plan of Care developed by your doctor or a team of health care workers under medical direction.

- 6. Respite Care** is short-term care provided in a nursing facility, in your home or in a community-based program, which is designed to relieve the primary care giver in your home.

When Will Long-Term Care Insurance Begin Paying Benefits?

All long-term care policies require that your physical or mental abilities be limited under one of three standards before benefits will be paid. These standards are often called Benefit Triggers. Many policies also require that additional conditions be met before you will receive payment. These “conditions” are events that must occur (or documents you must submit) after you meet the “benefit triggers” and before benefits will be paid.

The 3 Benefit Triggers permitted in long-term care insurance policies in California are:

1. Impairment in Activities of Daily Living (ADLs).

“Activities of Daily Living” (ADLs) are used to measure your physical abilities to determine if you qualify for benefits. The law requires tax-qualified policies to pay benefits if you are impaired in 2 out of the following 6 ADLs: bathing, dressing, transferring, eating, toileting and continence. For non-tax qualified policies, the requirement is for 2 out of the following 7 ADLs: ambulating, bathing, dressing, transferring, eating, toileting and continence. Note that the additional ADL for non-tax qualified policies is ambulating, which means walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

Only two ADLs can be required before benefits will be paid for nursing home care, RCFE care, or home care in policies sold after October 1, 2001.

“Impairment” means that you need human assistance or continual supervision to perform an Activity of Daily Living. Policies that trigger benefits when you only have to meet one of the ADLs may begin paying benefits earlier in your disability than if you have to meet two. However, your premiums will be higher and the policy will not be tax qualified.

2. Impairment in Cognitive Ability (or Cognitive Impairment).

“Impairment in Cognitive Ability” means that you need supervision or assistance to protect yourself or others because of mental deterioration caused by Alzheimer’s disease or any other mental disease. A doctor diagnoses cognitive impairment based on clinical evidence and by the use of standardized tests.

3. Medical Necessity

“Medical Necessity” usually means your doctor has certified that your medical condition will deteriorate if you do not receive the care recommended. However, under California law, an insurer is not allowed to require that your benefits also be “medically necessary” before the company will

pay. Federal law prohibits the use of a medical necessity trigger in tax-qualified long-term care insurance policies.

Conditions to the Payment of Benefits

All policies will require you to meet certain “conditions” after the “benefit triggers” have been met and before benefits will be paid.

Elimination Periods: The Elimination Period (sometimes called a “Waiting Period” or “Deductible Period”) is the period of time you must wait after you qualify for care, and are eligible to receive benefits before the company will begin paying for your care. You choose the length of the Elimination Period when you buy the policy. The most common options are 0 days, 30 days, 60 days, 90 days or 100 days. Some policies only make you meet the Elimination Period once during the life of the policy, others apply it again after you have gone for a certain period of time without needing care. In most situations the elimination period will be satisfied by a day of either in home care or institutional care. The premiums are usually more for short elimination periods and less for a longer one. Be sure to ask your qualified agent to explain these differences.

The elimination or deductible period is the length of time that the insurer pays no benefits. If you select a 0-day Elimination Period, the policy will begin paying on the first day you qualify for care. If you choose one of the other periods you will be responsible for paying the full cost of your care for these days.

Example: If you choose an Elimination Period of 60 days, you will be responsible for the cost of the first 60 days of your care. If you are in a nursing home that charges you \$100 per day, you will pay approximately \$6,000, before the policy starts paying. If you leave the nursing home before the 60 days expires and the policy only pays for institutional care, it would pay nothing for that period of care.

If you qualify for benefits in a home care setting most long-term care insurance policies apply a day towards your Elimination Period for any day you actually receive care (or a home care visit). Therefore, if your plan of care only calls for 3 visits per week you will only satisfy 3 days towards your Elimination Period. Some companies offer a more liberal interpretation of this definition. For example, the policy might say that if you have one home care visit per calendar week that you’ve satisfied 7 days towards your Elimination Period. In this example, you would satisfy your Elimination Period more quickly.

Several companies now utilize a “calendar day” definition for the elimination period. Once the insured has been certified as being chronically ill each calendar day counts towards the elimination period, regardless of whether formal long-term care services are received. This allows the insured person to get informal care from family or friends during the elimination period. After the elimination period has been satisfied formal paid care can begin.

The premium cost is usually higher if you choose the shorter Elimination Periods and is lower if you choose a longer period. In addition a premium might be higher when the company uses a more liberal “counting” of home care Elimination Period days. Also, make sure that the Elimination Period days that

are accumulated either in a home care or institutional care setting are combined to satisfy your overall elimination period. Be sure to ask your qualified agent to explain this.

Period of Care: A Period of Care usually begins on the first day you are eligible for benefits, and ends after a treatment-free interval during which you do not need any benefits. If you need care later, you may have to meet another Elimination Period.

Example: If your policy uses a 180-day treatment-free interval to measure the end of the Period of Care, and you leave the nursing home on June 1 and require no further care for 180 days, the Period of Care will end in 180 days on November 30. If you return to the nursing home before November 30, you will be in the same Period of Care and there will be no new Elimination Period. If you return to the nursing home again after November 30, you will have to pay your own expenses during a new Elimination Period.

Selecting the Elimination Period: Multiply the current cost of one day of care by the number of elimination days you plan to use. (Example: $\$141 \times 30 = \$4,230$)². Then estimate the number of days you could afford to pay for your own care without liquidating any assets. That is the maximum number of days you should select as an Elimination Period. Although choosing a short Elimination Period increases your premium, the amount you will pay for your own care during an Elimination Period is likely to be much more expensive. Another factor to take into account is that the daily cost of care doubles about every 14 years. Your out of pocket cost for the Elimination Period you choose will increase as well. Remember that short nursing home stays are more common than long stays and many people may need long-term care services more than once during their lifetime.

² The average daily cost in California in 2002.

Plan of Care: This is a plan written by your doctor or a medical team (such as a home health Agency's health care team) that establishes your need for care, and describes the kind of care you need, and the frequency of the required services. The Plan of Care is a familiar document to your doctor, hospital discharge planners, home health agencies and other health care providers who know about long-term care services. Many policies also require that the Plan of care be updated periodically to reflect any change in your need for care.

Care Management: Some policies include Care Management features. A Care Manager may assess your condition, consult with your doctor, establish a Plan of Care, follow your progress, and recommend care providers.

How Much Do Insurance Policies Pay for Long-Term Care?

1. The Daily Maximum

When you buy a policy you choose the amount you want the company to pay for each day of your care. Most companies allow you to select as little as \$50 daily or as much as \$500 daily. When you need care, companies pay the daily benefit you selected or the actual cost, whichever is less. Some benefits may be paid as a percentage of another. For instance, a policy may pay \$100 a day for care in a nursing home, 80 percent of that amount for assisted living in a Residential Care Facility for the Elderly

(RCFE), and 50 percent for home care. Policies sold after October 1, 2001 must pay a minimum of 70% of the daily nursing home benefit for RCFE care, except for Home Care Only policies that don't cover this kind of care.

Selecting the Daily Maximum

Because you will be responsible for all expenses not paid by your insurance policy, you need to decide how much of the daily cost of care you can pay yourself. Estimate the daily cost of long-term care in your community and subtract the amount you can afford to pay for each day of your care. For instance if the cost in your community is \$150 a day and you can afford to pay a co-payment of \$50 a day, you will need the insurance company to pay \$100 a day, or \$3,000 each month.

To help the benefits of your policy keep up with the annual increase in the cost of care due to inflation, every insurer is required to offer you Inflation Protection. Although Inflation Protection will increase your premium costs, without it you may not be able to afford to pay the difference between the cost of care when you need the long-term care services in the future and the amount of benefits your policy will pay. Remember that long-term care costs are likely to increase in the future. Unless you choose to add inflation protection, your benefits will remain static and you will have to pay out-of-pocket for the future increases in the cost of care.

Example: The average statewide cost of nursing home care in California in 2002 is \$141 a day or \$51,465 a year. A policy that pays \$141 a day would pay 100% of the daily charges for care in an average cost nursing home today. However, in approximately fourteen years, the average cost of care is estimated to double – a day of care will cost \$282 and a year of care \$102,930. Without inflation protection, the difference between the cost of care and the benefit will grow each year. In less than 14 years a \$141 daily benefit may cover as little as 50 percent of the cost of care.

2. The Maximum Lifetime Benefit

When you buy a long-term care policy, you choose the maximum dollar amount the policy will pay benefits over your lifetime. The approximate number of years you want the policy to pay benefits will determine the Maximum Lifetime Benefit. Policies are available with Maximum Lifetime Benefit amounts that pay benefits for approximately, one, two, three, four or five years or for your lifetime. The longer the period of coverage, the higher the premium. Your Lifetime Maximum Benefit is computed by multiplying the Daily Maximum benefit you select by the approximate number of days you want benefits to be paid. For example, the Lifetime Maximum Benefit will be \$36,500 if you select a Daily Maximum benefit of \$100 and want the policy to pay benefits for one year (365 days).

While everyone would like to buy Lifetime coverage or Unlimited benefits, not everyone can afford to do so. A policy that pays for a few years can provide valuable coverage, and for some people that will be all they will need. Don't pass up long-term care insurance just because you can't afford lifetime coverage.

Selecting the Maximum Lifetime Benefit

No one can predict how many days or years of long-term care a person will need, or the reason they will require care. Some people can afford lifetime coverage, others have so little money they would quickly qualify for Medi-Cal. Choosing the right amount of benefit depends on the premium you can afford, and the assets you would otherwise have to spend. Since the premium for Lifetime coverage is not

affordable for many people, here is one method of selecting the Maximum Lifetime Benefit. Choose the period that is roughly proportional to your current non-housing assets that you might otherwise have to use to pay for your care. (Remember that the value of your house is not counted when applying for Medi-Cal).

What Other Policy Features Are Available?

Inflation Protection

Most people buy long-term care many years in advance of when they may need care. The long-term care insurance you buy today must cover the costs of care 10, 20 or more years in the future. *Inflation Protection is intended to help maintain the value of the benefits you purchase today so they will keep up with future increases in the cost of care.* In the past, long-term care costs in California have increased at an annual rate of more than 5% - a faster rate than the general increase in the cost of living for items such as food. Experts estimate the cost of long-term care will continue to increase by 5% annually. If costs do increase by 5 % annually, the cost of care will double every 14 years. A day in a nursing home that costs \$141 today, will cost \$282 a day in 14 years; a year's stay in a nursing home that costs about \$51,465 today will cost \$102,930.

Protecting against the rising costs of care is one of the most important choices you will make. Inflation protection increases the Daily Maximum, the Maximum Lifetime Benefit, and other benefit amounts. If you purchase individual long-term care insurance, your insurer must offer you at the time you purchase the policy the option to purchase an inflation protection feature. You will be given a choice between two ways of protecting the value of your benefits against inflation: (1) a Built-in Inflation Protection feature that automatically increases the value of all the policy benefits annually (using either compound or simple interest increases) or; (2) a Benefit Increase Option.

1. ***Built-In Inflation Protection.*** The insurer is required by California law to offer you the option of a built-in 5% annual *compound inflation protection* feature that automatically increases your *previous year's* Daily Maximum and Lifetime Maximum Benefit amounts by 5%. If you decide not to purchase the built-in 5% compound annual inflation protection feature, you will be asked to sign a rejection of the offer. Some insurers may also offer you the option of a built-in 5% annual *simple inflation protection* that automatically increases each year the Daily and Lifetime Maximum Benefits by a *fixed* 5% of the amounts in your *original* policy.
2. ***Benefit Increase Option.*** The other inflation protection option is called a Benefit Increase Option. This option allows you to pay an additional premium to increase the benefit coverage amounts at stated intervals during the life of the policy (often referred to as guaranteed insurability or future purchase options). There is usually a limited number of increase options offered to you over the life of the policy. If you decide not to exercise this option one or more times when it is offered, you will lose any chances to increase your benefits in the future.

With built-in inflation protection, the premiums are designed to remain level and not increase even though your benefit coverage amounts increase each year. The increases in your benefits will continue as long as you keep the coverage, even while you are receiving benefits. Policies with built-in inflation

protection cost considerably more initially, since they automatically include the annual increases in benefits you need to keep pace with inflation.

Agents must show you an illustration of the effect of inflation on the cost of care, and how the benefits of a policy with and without inflation protection compare to the cost of care over time.

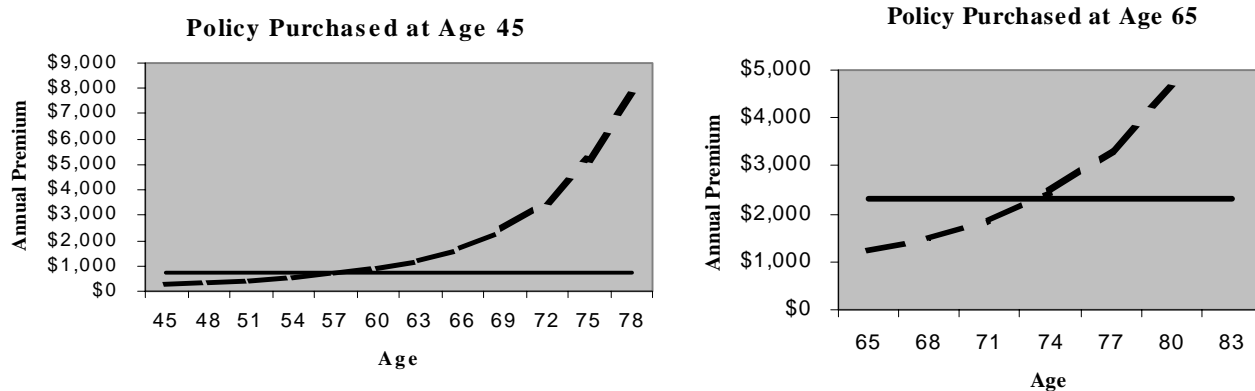
Example: If you choose a policy without inflation protection with a \$100 Daily Maximum and a Maximum Lifetime Benefit of \$36,500, your policy will only pay \$100 a day even if the daily cost of care has increased to \$200 and the cost of one year of long-term care has increased to \$73,000 in fourteen years. If you choose Built-in 5% *Compound* Inflation Protection, the Daily Benefit will be \$200 a day and the Maximum Lifetime Benefit will be \$73,000 in fourteen years. If you choose Built-in 5% *Simple* Inflation Protection, the Daily Maximum Benefit will be \$170 and the Maximum Lifetime Benefit will be \$62,050 after fourteen years. Remember: the cost of long-term care will double every 14 years if inflation continues at the current rate of 5% and your income is unlikely to keep up with inflation after retirement.

In most cases, you will be better off purchasing a policy with a lower Daily Maximum Benefit plus 5% compound inflation protection than selecting a policy with a higher Daily Maximum Benefit with no built-in annual inflation increases in benefits. This is because you are paying a higher premium in the early years for a higher daily benefit than you need, and as the years go by the benefit continues to decrease in relation to the cost of care. However, before you make a decision, you might want to consult with a financial planner, an attorney, a HICAP counselor or a family member.

With the Benefit Increase Option, your premium will increase each time you choose to accept the insurer's offer to increase the coverage amounts. The premium increase for each benefit upgrade will be based on the amount of coverage added and your age at the time you exercise the Benefit Increase Option. Because rates for older individuals are significantly higher and you will be older when each upgrade is offered, each Benefit Increase Option you accept will result in a larger premium increase than the prior offers. The advantage of the Benefit Increase Option is that the initial premium you pay for the policy will be much lower than if you choose the Built-in Inflation Protection Option. However, in the long run, you may end up paying more in total premiums to protect your benefits against inflation protection because of the additional premiums you must pay to purchase each Benefit Increase Option. And, as you get older and the premiums for the benefit upgrades get larger with each offer, you may not be able to afford the offer to upgrade your benefits unless your income increases significantly in retirement or you have substantial savings. In the long run, however, policies with built-in inflation protection are probably more cost-effective and the premium payments more predictable than the benefit increase option.

The graphs below illustrate how annual premiums for policies purchased at age 45 or 65 will differ over time for the Benefit Increase Option (dotted line) versus 5% compound Built-In Inflation Protection Option (solid line). (The graphs assume that inflation continues at 5% per year). The annual premiums you will pay if you accept each benefit upgrade option will rise over time under the Benefit Increase Option, while annual premiums for policies with Built-In Inflation Protection are designed to remain level. The Benefit Increase Option is therefore best suited only for those who expect to have increased income or assets or reduced financial obligations in the future.

ANNUAL PREMIUMS Benefit Increase Option vs. Built-In Inflation Protection Option



Premiums with Benefit Increase Option (-----)
 Premiums with Built-In Inflation Protection Option (_____)

Premium Discounts and Other Premium-Related Benefits

The premium you will pay may be adjusted from the 'normal' rate for a single individual. Many companies offer discounts if both spouses purchase Long-Term Care Insurance. Several provide discounts for those who do not use tobacco products and are the most healthy. Some companies provide that the policy of the surviving spouse is 'paid-up' when the first spouse dies - no further premium payments are required. A qualified agent can assist you in reviewing the options available.

What Consumer Protections Apply to Long-Term Care Insurance Sold in California?

California has a long list of consumer protections, some of which are listed here.

- **Renewability:** Every individual long-term care policy must be either guaranteed renewable or non-cancelable.
- **Guaranteed Renewable** means that the insurer may not cancel your coverage unless you do not pay premiums on time. Your coverage may not be cancelled because of your age or your health, but the company retains the right to increase premiums if the Department of Insurance approves the increase.

- **Non-cancelable** means that the insurer cannot cancel your coverage *or* increase your premiums, as long as you continue to pay your premiums on time. No company currently offers this type of coverage in California.
- **Group Coverage Renewability:** If you purchase a long-term care certificate through a group, you have the right to either continuation or conversion if your coverage terminates.
- **Continuation** means you maintain the same coverage if you continue to pay the premium on time.
- **Conversion** means you will be issued an individual policy containing identical or equivalent coverage regardless of your health or your age. The premium will be calculated on your age at the time the group certificate was issued.
- **Duty of Honesty, Good Faith and Fair Dealing:** Every long-term care insurer and insurance agent owes every applicant and policyholder a duty of honesty, good faith and fair dealing. Among other things, this duty means that advertisements and other marketing materials may not be misleading. Applicants must be given fair and accurate comparisons of policies. No excessive insurance or inappropriate replacement policies may be sold. High pressure tactics are expressly forbidden, and insurance agents must receive special training in order to sell long-term care insurance.
- **30-Day Free Look:** Purchasers of individual long-term care insurance (except purchasers through employer groups or trade associations) have the right to review the policy or certificate for 30 days after they receive it. If they decide not to buy the insurance, for any reason, they may return the policy to the insurer or the agent without explanation, and all the money they paid will be refunded to them. (Note: Always keep a record of the date you receive the policy and the date you return it, or return it by certified mail.)
- **Outline of Coverage:** An outline of coverage is a summary of the terms of a policy or certificate that you can use to compare different policies. An Outline of Coverage must be delivered to you at the time of an insurance agent's first presentation. If you are purchasing insurance through the mail, then the Outline of Coverage must be delivered to you at the time you receive the application or enrollment form. You do not need to fill out an application in order to get the Outline of Coverage. An agent or insurance company should be willing to give you an Outline of Coverage. If a company or an agent refuses to give you one, do business with someone else.
- **Changing Your Benefits:** If you find that you cannot afford to continue paying the same amount of premiums for the coverage you bought, you have the right to reduce your benefits in return for a lower premium. Companies must, at a minimum, let you reduce the daily benefit or change the number of years the company will pay benefits so the lower premium is an amount that is more affordable.
- **Shoppers Guide:** Companies and agents are required to give a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each person who applies for a long-term care insurance policy. This guide is titled "Taking Care of Tomorrow" and covers many issues related to long-term care, as well as long-term care insurance.
- **Checklist and Counseling Information:** Agents are required to leave a number of documents with you when they sell a long-term care insurance policy. Among the items you should get is a copy of a "Personal Worksheet" that helps you understand some of the issues related to purchasing long-term care insurance, and the name, address, and local phone number of the HICAP office nearest you where you can receive, free of charge, information and counseling about long-term care insurance.

Can I Afford Long-Term Care Insurance?

Most people should not spend more than 7% of their total annual income on annual premium for a long-term care insurance policy. Estimate your discretionary income by subtracting your fixed expenses from your annual income. Then decide how much of that discretionary income you want to spend on long-term care insurance premiums.

Remember that after retirement, income often does not keep pace with inflation. As you age you are more likely to have unexpected medical expenses, such as prescription drugs or other medical costs that may not be covered by your medical insurance. The loss of a spouse can also result in reduced income. Select a premium you can comfortably afford. Take into consideration that your premium may increase during the years you own the policy. When talking to an agent about long-term care insurance it is important for you and your agent to understand your financial circumstances so that he/she can tailor a plan best suited to your needs.

Should I Replace My Existing Policy with a Newer One?

The advantage of replacing an older policy is that newer policies may offer more desirable benefits and features and fewer restrictions. Assisted living in an RCFE, Home Care benefits, Inflation Protection, and no requirements for a prior hospital stay are some of the benefits and features being offered in current long-term care products. However, just because a policy is newer does not necessarily mean it is better than the one you have.

One disadvantage to replacement is that the insurance company will charge higher premiums because you are older than you were when you bought your original policy. In addition, if you have any preexisting conditions or are 80 years old or more, companies may refuse to issue new coverage. If you are still insurable you might consider adding new coverage to the benefits you already have, or buying an additional policy to supplement your existing benefits. Even very old policies still provide a benefit, and the premiums are often much less expensive than a premium for a brand new policy at an older age. Before you add benefits to an existing older policy you should check with your agent, company, or tax advisor to see if you will lose the grandfathered tax status granted policies purchased prior to January 1, 1997.

If you are considering replacing an older policy, first ask your current agent or insurer if you can update your coverage. If you replace your policy with the same company you are likely to get a credit for some percentage of the premiums you have already paid against the new premium. Another possibility is to keep the older policy and add a newer one to supplement the daily benefit in the old policy, or add some of the newer benefits not in the older policy. Adding another policy won't cause the loss of any tax advantages you have for the older policy. Whenever you are considering replacing a policy, consulting a HICAP counselor is recommended.

Before Buying Individual Long-Term Care Insurance, What Questions Should I Ask?

- Has this company increased premiums on policies it has sold to other consumers in California or in other states?
- How long has this company been selling long-term care insurance?
- What Nursing Homes, RCFEs and Home Care providers are near my home and covered by the policy?
- What are my choices for: Daily Maximum, Lifetime Maximum, Elimination Period and Inflation Protection?
- If the policy requires an Elimination Period, do I have to meet it only once, or more than once during my lifetime?
- May I hire anyone I choose to provide personal care and Homemaker Services under this policy? If not, what are the qualifications that care providers must meet?
- If the policy waives the premium:
 1. How is it waived?
 2. Does the waiver apply to all the benefits or only to nursing home care?
 3. What happens to any premiums I have already paid?

How Do I Choose a Qualified Long-Term Care Insurance Agent?

Here are some important things to determine about your prospective agent.

A qualified long-term care insurance agent should be able to help you sort through the clutter of company and benefit choices. Much of the decision making process revolves around your age, health conditions and financial suitability. In order to assist the agent in finding the best long-term care insurance policy for your needs, you need to find an agent you can trust and have a candid conversation with him/her regarding all of these matters.

How do you choose a qualified long-term care insurance agent?

Make sure the agent is certified to sell long-term care insurance. This means that he/she has taken two 8-hour certification courses within the last 24 months. If the agent has been licensed for less than five years, he or she will have taken an 8-hour certification course every 12 months. Agents selling the California Partnership policies will have taken an additional 8 hours of training that allows them to be a full-service long-term care insurance agent in California. Work with an agent who represents several companies. One size does not fit all. If an agent works with only one particular insurance company he or she may not be able to provide you with the best plan for your unique needs.

Make sure the agent is a member of one or more of many professional organizations such as:

- AALTCI – American Association for Long-Term Care Insurance
- CAHU – California Association of Health Underwriters
- Financial Planning Association
- CAIFA – California Association of Insurance and Financial Advisors
- NAIFA – National Association of Insurance and Financial Advisors
- PIA – Professional Insurance Agent
- IBA West – Independent Broker Association West
- Society of Financial Services Professionals

Additionally, the agent may have a professional designation such as CLU (Chartered Life Underwriter), ChFC(Chartered Financial Consultant) or CFP (Certified Financial Planner). Agents who participate in these organizations and have one or more of these designations typically adhere to a higher standard of ethics and education and are more likely to give you high quality service.

Notice if the agent asks the right questions. Without knowing your financial circumstances and health status the agent cannot possibly provide you with the best choices. A competent agent, should be able to show you what the premium would be from several companies for benefits that fit your needs and that you can afford.

A good agent will not just sell you a policy but will be there to help you when you have questions, need to make changes, or have a claim. Make sure that the agent you are working with has a good history and track record in providing on-going services to his/her clients. Don't be shy about asking for references. You can also check out an agent by going to the Department of Insurance website at www.insurance.ca.gov.

Before the agent leaves you should be provided with:

1. Outline of coverage
2. Personal Worksheet
3. The Buyer's Guide "Taking Care of Tomorrow"
4. The name, address and phone number of your local HICAP office

You should get these documents even if you don't agree to buy a policy that day.

Choosing an Insurance Company

An insurance company's financial standing and track record are important in choosing a long-term care insurance policy. Consumers should consider the rate increase data included on this website along with several other important factors.

Financial Standing

A company's size and ratings are important factors to take into consideration when making your long-term care insurance choice. While an A+ rating is no guarantee the company will remain in business or not increase their premiums, companies with superior ratings are more likely to have the ability to pay future claims. The rating services you should look to include:

<i>A.M. Best</i>	<i>(908) 439-2200</i>
<i>Standard & Poors</i>	<i>(212) 438-2000</i>
<i>Moody's</i>	<i>(212) 553-0377</i>
<i>Fitch Financial</i>	<i>(800) 753-4824</i>
<i>Weiss Ratings, Inc.</i>	<i>(800) 289-9222</i>

A.M. Best rates all long-term care insurance companies. Most carriers have ratings from one or more of the other services listed. These ratings will reflect the company's size (amount of assets and surplus). Ask your agent to provide you with the most recent rating statistics.

Underwriting Philosophy

Don't be discouraged by a company that carefully evaluates your health. Long-term care insurance companies that use firm and consistent underwriting standards should, over the long run, have more stable premiums. This is because they are careful about the risks they accept and likely to have more predictable claims results.

Don't be misled by the names attached to a company's underwriting classes (such as preferred, standard, substandard). You will not always qualify for a company's "preferred" rate class. What is important is that the company carefully reviews your health history, the results of your telephone interview and/or a face-to-face assessment and then makes an offer of insurance based on those results. "Easy-issue" offers mean that a company may be issuing insurance to people who already have serious health conditions and will definitely need long-term care. Such a practice can in turn lead to higher premiums for everyone who bought insurance from that company.

Group and Self-Insured Plans

Long-term care insurance offered on a group basis which is self-insured does not necessarily have the same strict consumer protection provisions that apply to individual long-term care insurance. Work with a qualified long-term care insurance agent to determine your priorities so that you can make the best choice for your long-term care insurance needs.

You Get What You Pay For

If a policy looks too “cheap” it probably is. Long-term care insurance has many optional benefits and nuances. Work with an agent who asks good questions and works with your personal situation to design a benefit package that suits your needs.

Longevity in the Long-Term Care Insurance Business

Long-term care insurance is a relatively new product. While a handful of companies have been offering long-term care insurance for a decade or more, there are many fine product offerings from high quality companies that have recently entered the marketplace. Some companies have long experience with this type of insurance, while others have less. Experience is just one more element to evaluate when purchasing this type of insurance.

Final Thoughts

The information in this rate guide can provide you with valuable insights when choosing the long-term care insurance company and policy that best suits your needs. No one element, however, should determine your choice. Try to view each element in perspective and balance them with your personal needs.